FOR OHF USE

LL1

2002

STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2002)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.		4792		II. CERTI	FICATION BY	AUTHORIZED FACILITY	OFFICER
	Facility Name: VILLA SCALABRINI NS Address: 480 N. WOLF ROAD Number County: COOK Telephone Number: (708) 562-0040 IDPA ID Number: 237061646008	NORTHLAKE City Fax # (708) 562-3955	60164 Zip Code	State o and cer are true applica is base Inter	f Illinois, for the tify to the best of accurate and of ble instructions donall informational misrepre	contents of the accompanying period from 07/01/0 of my knowledge and belief the complete statements in accordance. Declaration of preparer (oth tion of which preparer has an sentation or falsification of all be punishable by fine and/or	nat the said contents rdance with ner than provider) ny knowledge. ny information
	Date of Initial License for Current Owners: Type of Ownership: X VOLUNTARY,NON-PROFIT X Charitable Corp.	PROPRIETARY Individual	GOVERNMENTAL State	Officer or Administrator of Provider	(Type or Print (Title)		(Date)
	IRS Exemption Code	Partnership Corporation "Sub-S" Corp. Limited Liability Co. Trust Other	County Other	Paid Preparer	(Signed) (Print Name and Title) (Firm Name & Address) (Telephone)	Richard Sgarlata, CPA Frost, Ruttenberg & Rothbl 111 Pfingsten Road, Suite 30 (847) 236-1111	(Date) latt, P.C. 00 Deerfield, IL 60015 Fax # (847) 236-1155
	In the event there are further questions about Name: Steve Lavenda	this report, please contact: Telephone Number: (847) 236	- 1111		ILLI 201 S	L TO: OFFICE OF HEALTH NOIS DEPARTMENT OF PU . Grand Avenue East gfield, IL 62763-0001	

STATE OF ILLINOIS Page 2

Facil	lity Name & ID Numb	oer VILLA SCA	LABRINI NSG & R	EHAB			# 0044792 Report Period Beginning: 07/01/01 Ending: 06/30/02
	III. STATISTICA	L DATA					D. How many bed-hold days during this year were paid by Public Aid?
	A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 1 2 3 4 Beds at Beginning of Licensure Report Period Level of Care Report Period Report P				(Do not include bed-hold days in Section B.)		
							<u> </u>
	(g	_		_	E. List all services provided by your facility for non-patients.
	1	2		3	1		(E.g., day care, "meals on wheels", outpatient therapy)
	<u> </u>	<u></u>		<u> </u>			
	D. J 4				T		None
			_		•		F. Does the facility maintain a daily midnight census? Yes
	Report Period	Level of	Care	Report Period			
							G. Do pages 3 & 4 include expenses for services or
	144		/	144	52,560	1	investments not directly related to patient care?
		Skilled Pedi	atric (SNF/PED)			2	YES NO X
3	82	Intermediat	e (ICF)	82	29,930	3	
		Intermediat	e/DD			4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5	33	Sheltered C	are (SC)	33	12,045	5	YES NO X
6		ICF/DD 16	or Less			6	
							I. On what date did you start providing long term care at this location?
7	259	TOTALS		259	94,535	7	Date started 3/1/00
							J. Was the facility purchased or leased after January 1, 1978?
	B. Census-For	r the entire report per	riod.				YES X Date 3/1/00 NO
	1	2	3	4	5		
	Level of Care	Patient Days	by Level of Care an	d Primary Source of	Payment		K. Was the facility certified for Medicare during the reporting year?
				1			YES X NO If YES, enter number
		Recipient	Private Pav	Other	Total		of beds certified 13 and days of care provided 4,359
8	SNF	•	•		32,549	8	
		10,720	11,101	1,000	02,019	9	Medicare Intermediary AdminaStar Federal
		27 529	17 282		44 811	10	reductive interincediary reduction
		21,327	17,202		44,011	11	IV. ACCOUNTING BASIS
12		1,903	6,726		8,629	12	MODIFIED
	DD 16 OR LESS	1,505	0,720		0,027	13	ACCRUAL X CASH* CASH*
15	DD 10 OK LESS					10	Reckonii A Chon
14	TOTALS	46,188	35,442	4,359	85,989	14	Is your fiscal year identical to your tax year? YES X NO
	ı	,	/	,	, , , , ,		
		ccupancy. (Column 5,		tal licensed			Tax Year: 6/30/02 Fiscal Year: 6/30/02
	bed days or	n line 7, column 4.)	90.96%	_	CEE ACCOUNTS A	uma. cc	* All facilities other than governmental must report on the accrual basis.
					SEE ACCOUNTAI	112, CC	OMPILATION REPORT

Page 3 06/30/02 STATE OF ILLINOIS Facility Name & ID Number VILLA SCALABRINI NSG & REHAB 0044792 **Report Period Beginning:** 07/01/01 **Ending:**

	V. COST CENTER EXPENSES (through	ghout the report,	please round to	the nearest do	llar)							
			osts Per Genera	-		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	562,908	56,696		619,604		619,604		619,604			1
2	Food Purchase		467,902		467,902		467,902	(1,806)	466,096			2
3	Housekeeping	307,112	46,451		353,563		353,563		353,563			3
4	Laundry	146,173	69,091		215,264		215,264		215,264			4
5	Heat and Other Utilities			364,075	364,075		364,075		364,075			5
6	Maintenance	245,591	11,899	186,559	444,049		444,049	(7,790)	436,259			6
7	Other (specify):*											7
8	TOTAL General Services	1,261,784	652,039	550,634	2,464,457		2,464,457	(9,596)	2,454,861			8
	B. Health Care and Programs											
9	Medical Director			16,000	16,000		16,000		16,000			9
10	Nursing and Medical Records	3,822,844	274,172	353,996	4,451,012		4,451,012	3,920	4,454,932			10
10a	Therapy	142,150	4,651	543	147,344		147,344		147,344			10a
11	Activities	137,830	7,760	4,114	149,704		149,704	(298)	149,406			11
12	Social Services	285,748	5,127	6,094	296,969		296,969		296,969			12
13	Nurse Aide Training											13
14	Program Transportation			7,003	7,003		7,003	(1,695)	5,308			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,388,572	291,710	387,750	5,068,032		5,068,032	1,927	5,069,959			16
	C. General Administration											
17	Administrative	59,783		513,384	573,167		573,167	(513,384)	59,783			17
18	Directors Fees											18
19	Professional Services			5,376	5,376		5,376	238,344	243,720			19
20	Dues, Fees, Subscriptions & Promotions			6,646	6,646		6,646		6,646			20
21	Clerical & General Office Expenses	262,337	38,621	71,543	372,501		372,501	300,333	672,834			21
22	Employee Benefits & Payroll Taxes			1,675,026	1,675,026		1,675,026	74,294	1,749,320			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,944	2,944		2,944		2,944			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			486,209	486,209		486,209		486,209			26
27	Other (specify):*											27
28	TOTAL General Administration	322,120	38,621	2,761,128	3,121,869		3,121,869	99,587	3,221,456			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,972,476	982,370	3,699,512	10,654,358		10,654,358	91,918	10,746,276			29
	TOWING OF THE OF TO CO MO!	, , -	, -	, ,	, ,		APP (A A A TYPE)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	THE CALL THE CALL			

SEE ACCOUNTANTS' COMPILATION REPORT

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

#0044792

V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			i
	D. Ownership	1	2	3	4	5	6	7	8	9	10	1
30	Depreciation			658,394	658,394		658,394	16,050	674,444			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			35,665	35,665		35,665		35,665			35
36	Other (specify):*											36
37	TOTAL Ownership			694,059	694,059		694,059	16,050	710,109			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	32,751	270,314	48,210	351,275		351,275	(188,610)	162,665			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			123,735	123,735		123,735		123,735			42
43	Other (specify):*	106,023			106,023		106,023	(106,023)				43
44	TOTAL Special Cost Centers	138,774	270,314	171,945	581,033		581,033	(294,633)	286,400			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,111,250	1,252,684	4,565,516	11,929,450		11,929,450	(186,665)	11,742,785			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

0044792

Report Period Beginning:

07/01/01

Ending: 06/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	In column	2 Delow	1	2	T 3	LUST
			1	Refer-	OHF USE	
	NON-ALLOWABLE EXPENSES		Amount	ence	ONLY	
1	Day Care	\$			\$	1
2	Other Care for Outpatients					2
3	Governmental Sponsored Special Programs					3
4	Non-Patient Meals		(1,806)	2		4
5	Telephone, TV & Radio in Resident Rooms		(68)	21		5
6	Rented Facility Space					6
7	Sale of Supplies to Non-Patients					7
8	Laundry for Non-Patients					8
9	Non-Straightline Depreciation		499	30		9
10	Interest and Other Investment Income					10
11	Discounts, Allowances, Rebates & Refunds					11
12	Non-Working Officer's or Owner's Salary					12
13	Sales Tax			02		13
14	Non-Care Related Interest					14
15	Non-Care Related Owner's Transactions					15
16	Personal Expenses (Including Transportation)					16
17	Non-Care Related Fees					17
18	Fines and Penalties					18
19	Entertainment					19
20	Contributions					20
21	Owner or Key-Man Insurance					21
22	Special Legal Fees & Legal Retainers					22
23	Malpractice Insurance for Individuals					23
24	Bad Debt					24
25	Fund Raising, Advertising and Promotional					25
	Income Taxes and Illinois Personal			,		
26	Property Replacement Tax					26
27	Nurse Aide Training for Non-Employees					27
28	Yellow Page Advertising Other-Attach Schedule		(130 404)			28
29		Φ.	(139,406)		0	29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$	(140,781)		\$	30

B. If there are expenses experienced by the facility which do not appe	ar in the
general ledger, they should be entered below. (See instructions.)	

		1	Z	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(45,884)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (45,884)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (186,665)		37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

1 2 3

(~~	- 111501 Web101150)	_	_	•	-	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)		-	\$ _		47

	OHF USE ONL	Y				
48		49	50	51	52	

_	NON-ALLOWABLE EXPENSES	Amount	Reference	
1	Transportation	S (1,695)	14	1
2	Late Fee	(100)	21	2
3	Collections	(116)	21	7
-	Marketing Community Relations	(7,702)	21 21	4 41
6	Community Relations Capitalized Repairs & Maintenance	(8,570) (10,919)	6	6
7	Marketing Salary	(33,180)	43	7
8	Community Relations Salary	(72,843)	43	8
9	Miscellaneous Income	(3,983)	21	5
10	Event Income	(298)	- 11	10
11				1
12				1
13				1.
14				1
15				1:
16 17				1
18				13
19				1
20				20
21				2
22				23
23				2
24				2
25				24
26				2
27 28				2
29				2
30				3
31				3
32				3.
33				3.
34				3
35	-			3
36				3
37 38				3
39				3
40				4
41				4
42				4
43				4.
44				4
45				4
46				4
47				4
48				4
49 50				9
20				5
51 52				5
53				5
53 54 55				5
55				50
56				5
57				6
58 59				8
60				9
61				6
62				6
62 63				6.
64				6
65				6
66				6
67 68				6
68				6
70				7
71				7
72				7.
73 74				7.
74				7
7	-			7
76 77				7
17				7
78 79				7
79 80				8
81				8
82				8
83				8.
84	-			8
85				8
86 87				8
87 88				8
88				8
90				9
91				9
92				9.
93				9.
94				9.
95				9.
96	-			9
97		-		9
98 99				9
99				16
100				

STATE OF ILLINOIS Summary A # 0044792 Report Period Beginning: 07/01/01 **Ending:** 06/30/02

Facility Name & ID Number VILLA SCALABRINI NSG & REHAB **SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 61**

	SOMMER OF THOMS S, SH, S, SH												SUMMARY	
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6 I	(to Sch V, col.	.7)
1	Dietary													1
2	Food Purchase	(1,806)											(1,806)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(10,919)	3,129										(7,790)	6
7	Other (specify):*													7
8	TOTAL General Services	(12,725)	3,129										(9,596)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records		3,920										3,920	10
10a	Therapy													10a
11	Activities	(298)											(298)	
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation	(1,695)											(1,695)	
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(1,993)	3,920										1,927	16
	C. General Administration													
17	Administrative		(513,384)										(513,384)	
18	Directors Fees													18
19	Professional Services		238,344										238,344	19
20	Fees, Subscriptions & Promotions													20
21	Clerical & General Office Expenses	(20,539)	320,872										300,333	21
22	Employee Benefits & Payroll Taxes		74,294										74,294	22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	TOTAL General Administration	(20,539)	120,126										99,587	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(35,257)	127,175										91,918	29

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 61

													SUMMARY
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6Н	6 I	(to Sch V, col.7)
30	Depreciation	499	15,551										16,050 30
31	Amortization of Pre-Op. & Org.												31
32	Interest												32
33	Real Estate Taxes												33
34	Rent-Facility & Grounds												34
35	Rent-Equipment & Vehicles												35
36	Other (specify):*												36
37	TOTAL Ownership	499	15,551										16,050 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation												38
39	Ancillary Service Centers		(188,610)										(188,610) 39
40	Barber and Beauty Shops												40
41	Coffee and Gift Shops												41
42	Provider Participation Fee												42
43	Other (specify):*	(106,023)											(106,023) 43
44	TOTAL Special Cost Centers	(106,023)	(188,610)										(294,633) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(140,781)	(45,884)										(186,665) 45

Summary B

06/30/02

Ending:

0044792

Report Period Beginning:

07/01/01

06/30/02

VII. RELATED PARTIES

Facility Name & ID Number

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

A. Enter below the numes of A	ALE OWNERS and TO	ated organizations (parties) as defined in the instructions. Attach an additional schedule in necessary.							
1			3						
OWNERS		RELATED	OTHER RI	OTHER RELATED BUSINESS ENTITIES					
Name	Ownership %	Name	City	Name	City	Type of Business			
Resurrection Health Care		See Attached		See Attached					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	Schedule V		Line Item Amount Nam		Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V	21	Salary	\$	Resurrection Health Care		\$ 261,289	\$ 261,289	1
2	V	22	Employee Benefits		Resurrection Health Care		74,294	74,294	2
3	V	19	Data Processing		Resurrection Health Care		203,617	203,617	3
4	V	19	Purchasing		Resurrection Health Care		34,727	34,727	4
5	V		Operation of Plant		Resurrection Health Care		3,129	3,129	5
6	V		Nursing Administraton		Resurrection Health Care		3,920	3,920	6
7	V	21	Miscellaneous A&G		Resurrection Health Care		59,583	59,583	7
8	V	30	Capital		Resurrection Health Care		15,551	15,551	8
9	V								9
10	V	17	Intercompany Contracted Serv	513,384				(513,384)	10
11	V	39	Intercompany Pharmacy	188,610				(188,610)	11
12	V								12
13	V								13
14	Total			\$ 701,994			\$ 656,110	\$ * (45,884)	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

	ሰሴ	14	792
-	vv	44	174

07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

В.	Are any costs included in this report which are a result of transactions wit	h rela	ated organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

VILLA SCALABRINI NSG & REHAB

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	ո
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		o wheremp	\$	\$	15
16	V			-			-	-7	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

#	0044792

07/01/01

Page 6B Ending:

06/30/02

VII. RELATED PARTIES (continued)

B.	Are any costs included in this report which are a result of transactions wit	h rela	ated organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		•	\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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07/01/01

Page 6C **Ending:**

06/30/02

VII. RELATED PARTIES (continued)

В.	Are any costs included in this report which are a result of transactions wit	h rela	ted organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	ո
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		o wheremp	\$	\$	15
16	V			-			-	-7	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

#	004	147	92

07/01/01

Page 6D Ending:

06/30/02

VII. RELATED PARTIES (continued)

В.	Are any costs included in this report which are a result of transactions wit	h rela	ited organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		•	\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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07/01/01

Page 6E Ending:

06/30/02

VII. RELATED PARTIES (continued)

B.	Are any costs included in this report which are a result of transactions wit	h rela	ated organizati	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
					Percent	Operating Cost	Adjustments for	
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
					Ownership	Organization	Costs (7 minus 4)	
15 V			\$			\$	\$	15
16 V								16
17 V								17
18 V								18
19 V								19
20 V								20
21 V								21
22 V								22
23 V								
24 V								24
25 V								25
26 V								26
27 V								27
28 V								28
29 V								29
30 V								30
31 V								31
32 V								32
33 V								33
34 V								34
35 V								35
36 V								36
37 V								37
38 V								38
39 Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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07/01/01

Ending:

06/30/02

Page 6F

VII. RELATED PARTIES (continued)

B.	Are any costs included in this report which are a result of transactions wit	h rela	ted organizat	ions?	This includes rent
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	ո
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		o wheremp	\$	\$	15
16	V			-			-	-7	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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Page 6G **Ending:**

06/30/02

VII. RELATED PARTIES (continued)

В.	Are any costs included in this report which are a result of transactions wit	h rela	ated organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		•	\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

#	0044792

07/01/01

Page 6H **Ending:**

06/30/02

VII. RELATED PARTIES (continued)

В.	Are any costs included in this report which are a result of transactions wit	h rela		
	management fees, purchase of supplies, and so forth.		YES	NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
					Percent	Operating Cost	Adjustments for	
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	ո
Schedule v		Tem	7 mount	Traine of Related Organization				•
15 V	_		\$		Ownership	Organization	Costs (7 minus 4)	15
16 V	+		3			3	3	16
10 V								17
18 V								18
19 V	+							19
20 V								20
21 V				,				21
22 V								22
23 V								23
24 V								24
25 V								25
26 V								26
27 V								27
28 V								28
29 V								29
30 V								30
31 V								31
32 V								32
33 V								33
34 V								34
35 V								35
30 1								36
37 V								37
30 Y								38
39 Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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07/01/01

Page 6I **Ending:**

06/30/02

VII. RELATED PARTIES (continued)

В.	Are any costs included in this report which are a result of transactions wit		
	management fees, purchase of supplies, and so forth.	YES	NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	ո
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		o whership	\$	\$	15
16	V			-			-	-7	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

Page 7

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5		6	7		8	
						Average Hou	ırs Per Work				
					Compensation	Week Dev	oted to this	Compensation	on Included	Schedule V.	
					Received	Facility and	l % of Total	in Costs	for this	Line &	
				Ownership	From Other	Work	Week	Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).

FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,

ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

0044792 Report Period Beginning:

07/01/01

Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	Resurrection HC/Medical Center
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	7435 W. Talcott
or parent organization costs? (See instructions.) YES X NO	City / State / Zip Code	Chicago, IL 60631
	Phone Number	(773) 774-8000
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	773) 594-7488

	1	2	3	4	5	6	7	8	9	\Box
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1		Salary	•		5	\$	\$		\$ 261,289	1
2	22	Employee Benefits							74,294	2
3		Data Processing							203,617	3
4	19	Purchasing							34,727	4
5		Operaton of Plant							3,129	5
6	10	Nursing Administration							3,920	6
7	21	Miscellaneous A&G							59,583	7
8	30	Capital							15,551	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 656,110	25

VIII.	ALLC	CATION	OF INDIRECT	COSTS
-------	------	--------	-------------	-------

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.) YES NO	City / State / Zip Code	
	Phone Number	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	\Box
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			% q 0 2 000)			\$	\$	0.000	\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15 16										15 16
17										17
18										18
19										19
20										20
21										21
22										22
23										22 23
24										24
	TOTALS					s	\$		s	25

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07/01/01

Ending: 06/30/02

VIII.	ALI	OCATION	OF INDIRECT	COSTS
-------	-----	---------	-------------	-------

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.) YES NO	City / State / Zip Code	
	Phone Number	()
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14 15										14 15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
	TOTALS					s	\$		s	25

#	00

07/01/01

Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.) YES NO	City / State / Zip Code	
	Phone Number	()
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	\Box
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			% q 0 2 000)			\$	\$	0.000	\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15 16										15 16
17										17
18										18
19										19
20										20
21										21
22										22
23										22 23
24										24
	TOTALS					s	\$		s	25

#	0044792

07/01/01

Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.)	City / State / Zip Code	
	Phone Number	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13 14
14										15
15 16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
	TOTALS					s	\$		S	25

07/01/01

Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.)	City / State / Zip Code	
	Phone Number	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	\Box
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			% q 0 2 000)			\$	\$	0.000	\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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15 16										15 16
17										17
18										18
19										19
20										20
21										21
22										22
23										22 23
24										24
	TOTALS					s	\$		s	25

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07/01/01

Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.) YES NO	City / State / Zip Code	
	Phone Number	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			,		<i>g</i>	\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

0044792 Report Period Beginning:

07/01/01

Ending: 06/30/02

VIII	ALLO	CATION	OF INDIRECT	COSTS
V 111.	A	7. A I II II I	UP INDIKEA I	111515

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.) YES NO	City / State / Zip Code	
	Phone Number	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•		Ŭ	\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12 13
13 14										13
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
	TOTALS					\$	\$		\$	25

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07/01/01

Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.) YES NO	City / State / Zip Code	
	Phone Number	()
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	110101 CHCC	Ttom	Square reet)	10tal Chits	Timocarca Timong	S	\$	Cints	\$	1
2							4		•	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20 21
21										21
22										22 23
23										
24										24
25	TOTALS					\$	\$		\$	25

07/01/01

Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COS	STS
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	Name of Related Organization
A. Are there any costs included in this report which were derived from allocations of central office	Street Address
or parent organization costs? (See instructions.) YES NO	City / State / Zip Code
	Phone Number ()
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	1101010101		z quare 1 cccy	1000101105		S	\$	0 11105	S	1
2						-	-			2
3										3
4										4
5										5
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18									 	18
19									 	19
20									<u> </u>	20 21
21									<u> </u>	
22										22
24										24
	TOTALO					0	0		0	
25	TOTALS					\$	\$		\$	25

		STATE OF ILLINOIS					Page 9
Facility Name & ID Number	VILLA SCALABRINI NSG & REHAB	# (0044792	Report Period Beginning:	07/01/01	Ending:	06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amou Original	int of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related	TES 110		required	11000	Originar	Bulance		(T Digits)	Expense	
	Long-Term										
1				l		\$	s			\$	1
2						·					2
3											3
4											4
5											5
	Working Capital										
6											6
7											7
8											8
9	TOTAL Facility Related					\$	\$			s	9
	B. Non-Facility Related*		T		l		I	Ī		I	10
	See Supplemental Schedule										10 11
11 12											12
13											13
13											15
14	TOTAL Non-Facility Related					\$	\$			\$	14
15	TOTALS (line 9+line14)					\$	s			\$	15

¹⁶⁾ Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line #

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

0044792 Report Period Beginning:

Page 10 06/30/02

07/01/01 Ending:

Facility Name & ID Number VILLA SCALABRINI NSG & REHAB

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)
B. Real Estate Taxes

	Important, please see the next worksheet, "RE_Tax". The	real e	estate tax statement and				
1. Real Estate Tax accrual used on 2001 report.	h 11 march and an arm and the continue and						
2. Real Estate Taxes paid during the year: (Indicate the ta	\$	2					
3. Under or (over) accrual (line 2 minus line 1).	\$	3					
	and explain your calculation of this accrual on the lines below.)			\$	4		
	5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)						
6. Subtract a refund of real estate taxes. You must offset classified as a real estate tax cost plus one-half of any restart tax cost plus one-half of any restart tax.	•	6					
7. Real Estate Tax expense reported on Schedule V, line	Tax Year. (Attach a copy of the real estate tax apparents of the should be a combination of lines 3 thru 6.	pou.		\$	7		
Real Estate Tax History:					,		
Real Estate Tax Bill for Calendar Year: 1997	8		FOR OHF USE ONLY				
1998 1999	9 10	13	FROM R. E. TAX STATEMENT FOR	R 2001 \$	13		
2000 2001	11 12	14	PLUS APPEAL COST FROM LINE 5	5 \$	14		
		15	LESS REFUND FROM LINE 6	\$	15		
		16	AMOUNT TO USE FOR PATE CALC	ZULATION ©	16		

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

	IMPORTANT NOTICE							
TO: Lo	ong Term Care Facilities with Real Estate Tax Rates	RE:	2001 REAL ESTATE TAX COST DOCUMENTATION					
In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.								
	Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.							

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

	2001 LONG TE	RM CARE REAL ESTATE	TAX STATEME	NT				
FAC	CILITY NAME VILLA SCALA	BRINI NSG & REHAB	COUNTY CO	OOK				
FAC	CILITY IDPH LICENSE NUMBER	0044792						
CO	NTACT PERSON REGARDING TH	IS REPORT						
		FAX #: (
A.	Summary of Real Estate Tax Cos			_				
Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the numbome property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.								
	(A)	(B)	(C)	(D) Tax				
				Applicable to				
	Tax Index Number	Property Description	Total Tax	Nursing Home				
1.			\$	\$				
2.			\$	\$				
3.			\$	\$				
4.			\$	s				
5. 6.			\$	\$				
7.			\$	\$				
8.			\$ \$	\$ \$				
9.			\$	\$				
10.			\$	\$				
				· <u>········</u>				
		TOTALS	\$	\$				
В.	Real Estate Tax Cost Allocations							
Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not used for nursing home services? YES NO								
		chedule which shows the calculation of nust be allocated to the nursing home ba						
C.	Tax Bills							
	Attach a copy of the 2001 tax bills is normally paid during 2002.	which were listed in Section A to this s	tatement. Be sure to use	the 2001 tax bill which				

ĺ	IMPORTANT NOTICE						
	TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION						
	In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.						
	Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.						

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

	2000 LONG TI	ERM CARE REAL ESTATE	TAX STATEME	NT
FAC	CILITY NAME VILLA SCALA	ABRINI NSG & REHAB	COUNTY CO	OOK
FAC	CILITY IDPH LICENSE NUMBER	0044792		
CON	NTACT PERSON REGARDING TH	HIS REPORT		
		FAX #: (
A.	Summary of Real Estate Tax Co	<u>st</u>		
	cost that applies to the operation o home property which is vacant, re-	al estate tax assessed for 2000 on the lin f the nursing home in Column D. Real nted to other organizations, or used for p ude cost for any period other than calend	estate tax applicable to an ourposes other than long t	y portion of the nursing
	(A)	(B)	(C)	(D) Tax
	Tax Index Number	Property Description	Total Tax	Applicable to Nursing Home
1.			\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.	-		\$	\$
7.			\$	\$
8. 9.			\$	\$
10.			\$ \$	\$ \$
				*
		TOTALS	\$	\$
В.	Real Estate Tax Cost Allocation	s		
		ply to more than one nursing home, vac-		which is not directly
		schedule which shows the calculation of must be allocated to the nursing home by		
C.	Tax Bills			
	Attach a copy of the 2000 tax bills is normally paid during 2001.	which were listed in Section A to this s	tatement. Be sure to use	the 2000 tax bill which

Facil	ity Name & ID Number VILLA SCA	LABRINI NSG & REHAB		# 0044792	Report Period Begin	ning:	07/01/01 Ending:	06/30/02
X. B	UILDING AND GENERAL INFORM	IATION:						
A.	Square Feet: 195,17	B. General Construction Type:	Exterior	Brick	Frame Steel/Con	crete	Number of Stories	1
C.	Does the Operating Entity?	X (a) Own the Facility	(b) Rent from a	a Related Organization	l•		(c) Rent from Completely Unre Organization.	lated
	(Facilities checking (a) or (b) must c	complete Schedule XI. Those checking (c)	may complete Schedule	XI or Schedule XII-A	See instructions.)			
D.	Does the Operating Entity?	X (a) Own the Equipment	(b) Rent equip	ment from a Related O	rganization.	X	(c) Rent equipment from Comp Unrelated Organization.	oletely
	(Facilities checking (a) or (b) must c	complete Schedule XI-C. Those checking	(c) may complete Schedu	ule XI-C or Schedule X	III-B. See instructions)	S	
E.	List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).							
	None							
F.	Does this cost report reflect any org If so, please complete the following:	anization or pre-operating costs which a	re being amortized?		YES	X	NO	
1.	. Total Amount Incurred:			2. Number of Years O	ver Which it is Being	Amortized:		
3.	. Current Period Amortization:			4. Dates Incurred:				
		Nature of Costs: (Attach a complete schedule deta	ailing the total amount o	f organization and pre	-operating costs.)			
XI. C	OWNERSHIP COSTS:							
. ~		1	2	3	4			
	A. Land.	Use	Square Feet	Year Acquired	Cost			
		1 Facility	696,960	200	1,500	0,000 1		
		3 TOTALS	696,960		\$ 1,500	,000 3		

STATE OF ILLINOIS

Page 11

0044792

Facility Name & ID Number VILLA SCALABRINI NSG & REHAB XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	ing Depreciation-including Fixed Eq	2	3		4	5	6	7	8	9	\Box
		FOR OHF USE ONLY	Year	Year			Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed		Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4					\$	7,510,695	\$ 252,512	35	\$ 252,512	\$	\$ 643,665	4
5												5
6												6
7												7
8												8
		ovement Type**	•									
9	Illuminated I	Display sign		8/28/2000		9,374	469	20	469		938	9
10	Redecorating			1/26/2001		6,181	310	20	310		620	10
	Sign			3/21/2001		6,805	340	20	340		680	11
	Roof Repair			5/11/2001		4,246	212	20	212		424	12
	Condenser			8/21/2000		2,185		20	109	109	218	13
14	Monitoring S	ystem		8/14/2000		1,592		20	80	80	160	14
	Refrigeration			1/4/2001		1,650		20	82	82	164	15
	Air Conditioning Repair			7/16/2001		576		20	29	29	29	16
	Display			11/21/2001		1,629		20	81	81	81	17
	Kitchen Floo			2/14/2002		625		20	31	31	31	18
	Air Condition	ning Repair		2/28/2002		744		20	37	37	37	19
20				4/5/3003		4.000		4.0	-		70	20
	Electrical Wi	ring		4/5/2002		1,000		20	50	50	50	21
	Roof Repair	X. 1		11/30/2001		614	31	20	31		31	22
	Illuminated I	Display		7/31/2001 2/6/2002		4,199	210	20	210		210	23
	Renovations			2/8/2002		2,385 2,100	119 105	20	119		119	24 25
	Canopy Sewer Line			4/30/2002		4,200	210	20	105 210		105 210	26
27	Sewer Line			4/30/2002		4,200	210	20	210		210	27
	Allocation fre	om Resurrection Health Care					13,493		13,493			28
29	Anocation Ir	om resurrection ficatul Care					13,773		13,773			29
30					-							30
31												31
32												32
33								1				33
34					 							34
35												35
36				<u> </u>								36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total SEE ACCOUNTANTS' COMPILATION REPORT

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

0044792

Facility Name & ID Number VILLA SCALABRINI NSG & REHAB XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	Т
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57 58
59								59
60								60
61								61
62								62
63								63
64			+					64
65			+					65
66								66
67			+					67
68 Related Party Allocations (Page 12-REP & Page 12A-REP)								68
69 Financial Statement Depreciation								69
69 Financial Statement Depreciation 70 TOTAL (lines 4 thru 69)		\$ 7,560,800	\$ 268,011		\$ 268,510	\$ 499	\$ 647,772	70

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

Facility Name & ID Number VILLA SCALABRINI NSG & REHAB

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar,

B. Building Depreciation-Including Fixed Equipment. (See insti	3	4	5	6	7	8	9	Т
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 7,560,800	\$ 268,011				\$ 647,772	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11 12								11 12
13								13
14								14
15								15
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18								18
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21								21
22								22
23								23
24								24
25 26								25 26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 7,560,800	\$ 268,011		\$ 268,510	\$ 499	\$ 647,772	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

Facility Name & ID Number VILLA SCALABRINI NSG & REHAB

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

B. Building Depreciation-including Fixed Equipment. (See	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 7,560,800	\$ 268,011		\$ 268,510	\$ 499	\$ 647,772	1
2								2
3								3
4								4
5								5
6								6
7								7
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21 22								21 22
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26								26
27								27
28								28
29			+	1				29
30								30
31								31
32				1				32
33								33
34 TOTAL (lines 1 thru 33)		\$ 7,560,800	\$ 268,011		\$ 268,510	\$ 499	\$ 647,772	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

Facility Name & ID Number VILLA SCALABRINI NSG & REHAB

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	\top
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 7,560,800	\$ 268,011		\$ 268,510	\$ 499	\$ 647,772	1
2								2
3								3
4								4
5								5
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7								7
8								8
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28								28
29								29
30								30
31								31
32								32
33			2.000			10.5		33
34 TOTAL (lines 1 thru 33)		\$ 7,560,800	\$ 268,011		\$ 268,510	\$ 499	\$ 647,772	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

Facility Name & ID Number VILLA SCALABRINI NSG & REHAB

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	dung rixed Equipment. (See instr	3		4	5	6	7	8		9	T
T		Year	63		Current Book	Life	Straight Line	1		cumulated	
Improvement Type**		Constructed		ost	Depreciation	in Years	Depreciation	Adjustments		preciation	
1 Totals from Page 12D, Carried Fo	orward		\$ 7,5	60,800	\$ 268,011		\$ 268,510	\$ 499	\$	647,772	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
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22 23											22 23
24 25											24 25
25 26											26
27									<u> </u>		27
28											28
29									+		29
30											30
31									+		31
32									+		32
33								+	+		33
34 TOTAL (lines 1 thru 33)			\$ 7,5	60,800	s 268,011		\$ 268,510	\$ 499	\$	647,772	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number VILLA SCALABRINI NSG & REHAB XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	T
	Year		Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12E, Carried Forward		\$ 7,560,800	\$ 268,011		\$ 268,510	\$ 499	\$ 647,772	1
2								2
3								3
4								4
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21								21 22
22 23								23
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25	+							25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 7,560,800	\$ 268,011		\$ 268,510	\$ 499	\$ 647,772	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number VILLA SCALABRINI NSG & REHAB XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar.

	B. Building Depreciation-Including Fixed Equipment. (See inst	3	4	5	6	7	1 8	9	$\overline{1}$
		Year		Current Book	Life	Straight Line		Accumulated	
	Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 7,560,800	\$ 268,011		\$ 268,510	\$ 499	\$ 647,772	1
2	Totals from ruge 121, Curricultor ward		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				*		2
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28									28
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30									30
31									31
32			<u> </u>						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,560,800	\$ 268,011		\$ 268,510	\$ 499	\$ 647,772	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number VILLA SCALABRINI NSG & REHAB XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	\top
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
1 Totals from Page 12G, Carried Forward		\$ 7,560,800	\$ 268,011		\$ 268,510	\$ 499	\$ 647,772	1
2								2
3								3
4								4
5								5
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25	1							25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33						10.5		33
34 TOTAL (lines 1 thru 33)		\$ 7,560,800	\$ 268,011		\$ 268,510	\$ 499	\$ 647,772	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number VILLA SCALABRINI NSG & REHAB XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	\top
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
1 Totals from Page 12H, Carried Forward		\$ 7,560,800	\$ 268,011		\$ 268,510	\$ 499	\$ 647,772	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17 18								17 18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 7,560,800	\$ 268,011		\$ 268,510	\$ 499	\$ 647,772	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number VILLA SCALABRINI NSG & REHAB XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	ing Depreciation-including Fixed Equi	2	3	4	5	6	7	8	9	\Box
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
4			•		\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Impr	ovement Type**									
9		••									9
10											10
11											11
12											12
13											13
14											14
15											15
16											16 17
17 18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A-REP, Line 70 for total SEE ACCOUNTANTS' COMPILATION REPORT

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number VILLA SCALABRINI NSG & REHAB XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	\Box
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51 52								51 52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69						0		69
70 TOTAL (lines 4 thru 69)		\$	S		IS	\$	\$	70

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Report Period Beginning:

07/01/01 **Ending:** 06/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of	ĺ	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 1,957,983	\$ 397,766	\$ 397,766	\$	10	\$ 985,390	71
72	Current Year Purchases	75,321	8,168	8,168		10	8,168	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,033,304	\$ 405,934	\$ 405,934	\$		\$ 993,558	75

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets		1	2		
		Reference	Amount		i
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 11,094,104	81	i
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 673,945	82	i
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 674,444	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 499	84	l
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,641,330	85	i

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

Ending: 06/30/02

XII.	RE	N	[A]	L (CO	51	IS

Facility Name & ID Number

- A. Building and Fixed Equipment (See instructions.)
- 1. Name of Party Holding Lease: N/A
- 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. YES NO

		1	2	3	4	5	6	
		Year	Number	Date of	Rental	Total Years	Total Years	
		Constructed	of Beds	Lease	Amount	of Lease	Renewal Option*	
	Original							
3	Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10115					
				5	
				6	11. Rent to be paid in future years under the current
AL .		\$		7	rental agreement:

8. List separately any amortization of lease expense included on page 4, line 34.	
This amount was calculated by dividing the total amount to be amortized	
by the length of the lease	

9. Option to Buy:	YES	NO Terms:	*

Fiscal Yea	ir Ending	Annual Rent	
12.	/2003	\$	
13.	/2004	\$	
14	/2005	•	

10. Effective dates of current rental agreement:

Beginning

- B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.) 15. Is Movable equipment rental included in building rental?

10. 15 1/10 tubic equipment rentui included in	Dulla	mg remem.		125	
16. Rental Amount for movable equipment:	\$	35,665	Description:	See attached sch	edu

ttaciicu st	licuuic					
(Attach a	schedule	detailing t	he break	down of m	iovable equ	inment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

- * If there is an option to buy the building, please provide complete details on attached schedule.
- ** This amount plus any amortization of lease expense must agree with page 4, line 34.

Report Period Beginning:

07/01/01 Ending:

06/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)						
1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	YES	2. <u>CLASSROOM</u> IN-HOUSE PR			3. <u>CLINICAL PORTION:</u> IN-HOUSE PROGRAM	
rekiod;	X NO	IN OTHER FA			IN OTHER FACILITY	
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was		COMMUNITY	COLLEGE		HOURS PER AIDE	
not necessary.		HOURS PER A	AIDE			
B. EXPENSES	ALLOCAT	TION OF COSTS	(d)		C. CONTRACTUAL INCOME	
	1	2	3	4	In the box below record the amount of income your facility received training aides from other facilities.	
	Drop-outs	acility Completed	Contract	Total	•	
1 Community College Tuition	\$	\$	\$	S	<u>\</u>	
2 Books and Supplies		-			D. NUMBER OF AIDES TRAINED	
3 Classroom Wages (a)						
4 Clinical Wages (b)					COMPLETED	
5 In-House Trainer Wages (c)					1. From this facility	
6 Transportation					2. From other facilities (f)	
7 Contractual Payments 8 Nurse Aide Competency Tests					DROP-OUTS 1. From this facility	
9 TOTALS	\$	\$	\$	S	2. From other facilities (f)	
10 SUM OF line 9, col. 1 and 2 (e)	s	Ψ	ΙΨ	<u> </u>	TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

 SEE ACCOUNTANTS' COMPILATION REPORT

Ending:

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

2 5 Schedule V **Outside Practitioner Supplies** Staff (Actual or) **Total Units** Service Line & Column Units of Cost **Total Cost** (other than consultant) Reference Allocated) (Column 2 + 4)(Col. 3 + 5 + 6)Service Units Cost **Licensed Occupational Therapist** 24,073 47,798 71,871 39 - 01 hrs **Licensed Speech and Language Development Therapist** 412 39 - 01 hrs 3,249 3,661 **Licensed Recreational Therapist** hrs **Licensed Physical Therapist** 39 - 01 hrs 5,429 5,429 Physician Care visits **Dental Care** visits 6 Work Related Program hrs Habilitation hrs 8 # of Pharmacy 39 - 02 188,610 188,610 prescrpts Psychological Services (Evaluation and Diagnosis/ **Behavior Modification)** hrs 10 **Academic Education** hrs **Exceptional Care Program** 12 13 Other (specify): See Supplemental 81,704 81,704 13 TOTAL 32,751 48,210 270,314 351,275

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

07/01/01

Ending:

VILLA SCALABRINI NSG & REHAB Facility Name & ID Number

Report Period Beginning: (last day of reporting year) 06/30/02 As of

XV. BALANCE SHEET - Unrestricted Operating Fund.

This report must be completed even if financial statements are attached.

	I his report must be completed even	1		2 After	
		(Operating	Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	873,324	\$	1
2	Cash-Patient Deposits				2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance		2,246,694		3
4	Supply Inventory (priced at)				4
5	Short-Term Investments				5
6	Prepaid Insurance				6
7	Other Prepaid Expenses		8,483		7
8	Accounts Receivable (owners or related parties)				8
9	Other(specify): See Supplemental Schedule		52,290		9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	3,180,791	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land		1,500,000		13
14	Buildings, at Historical Cost		7,541,249		14
15	Leasehold Improvements, at Historical Cost		3,250		15
16	Equipment, at Historical Cost		1,997,852		16
17	Accumulated Depreciation (book methods)		(1,505,378)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs		78,000		19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs		(20,800)		20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify): See Supplemental Schedule		297,647		23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	9,891,820	\$	24
	TOTAL ASSETS	1			
25	(sum of lines 10 and 24)	\$	13,072,611	\$	25

		1	perating	2 After Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	63,498	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits		48,181		28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable				30
	Accrued Taxes Payable				
31	(excluding real estate taxes)				31
32	Accrued Real Estate Taxes(Sch.IX-B)				32
33	Accrued Interest Payable				33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	See Supplemental Schedule		1,882,592		36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	1,994,271	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable				40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				•
43	See Supplemental Schedule				43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$		\$	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	1,994,271	\$	46
-	-,		<i>y y</i>		
47	TOTAL EQUITY(page 18, line 24)	\$	11,078,340	\$	47
• •			-,,- ••	-	
	TOTAL LIABILITIES AND EQUITY	(

	IANGES IN EQUIT I	1		1
			1	
<u> </u>		Φ.	Total	4
1	Balance at Beginning of Year, as Previously Reported	\$	11,171,394	1
2	Restatements (describe):			2
3				3
4				4
5				5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	11,171,394	6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		(93,054)	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe)			15
16	Other (describe)			16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	(93,054)	17
	B. Transfers (Itemize):			
18				18
19				19
20				20
21				21
22				22
23	TOTAL Transfers (sum of lines 18-22)	\$		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	11,078,340	24

* This must agree with page 17, line 47.

0044792

Report Period Beginning:

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

Revenue			1	
1 Gross Revenue All Levels of Care \$ 13,915,440 1 2 Discounts and Allowances for all Levels (3,384,319) 2 3 SUBTOTAL Inpatient Care (line 1 minus line 2) \$ 10,531,121 3 B. Ancillary Revenue			Amount	
2				
SUBTOTAL Inpatient Care (line 1 minus line 2) S 10,531,121 3	_		\$	
B. Ancillary Revenue				
4 Day Care 5 Other Care for Outpatients 5 6 Therapy 599,550 6 7 Oxygen 7 8 SUBTOTAL Ancillary Revenue (lines 4 thru 7) \$ 599,550 8 C. Other Operating Revenue 9 Payments for Education 9 10 Other Government Grants 10 11 Nurses Aide Training Reimbursements 11 12 Gift and Coffee Shop 12 13 Barber and Beauty Care 13 14 Non-Patient Meals 1,806 14 15 Telephone, Television and Radio 68 15 16 Rental of Facility Space 16 17 Sale of Drugs 317,888 17 18 Sale of Supplies to Non-Patients 18 19 Laboratory 129 19 20 Radiology and X-Ray 20 21 Other Medical Services 317,478 21 22 Laundry 54,658 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) 692,027 23 D. Non-Operating Revenue 24 Contributions 24 25 Interest and Other Investment Income*** 7,622 26 E. Other Revenue (specify):**** 27 Settlement Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 6,076 28 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) 5 6,076 29	3	• ,	\$ 10,531,121	3
5 Other Care for Outpatients 5 6 Therapy 599,550 6 7 Oxygen 7 8 SUBTOTAL Ancillary Revenue (lines 4 thru 7) \$ 599,550 8 C. Other Operating Revenue 9 Payments for Education 9 10 Other Government Grants 10 11 11 Nurses Aide Training Reimbursements 11 11 12 Gitt and Coffee Shop 12 13 13 Barber and Beauty Care 13 1,806 14 15 Telephone, Television and Radio 68 15 16 Rental of Facility Space 16 16 17 Sale of Drugs 317,888 17 18 Sale of Supplies to Non-Patients 18 18 19 Laboratory 129 19 20 Radiology and X-Ray 20 20 21 Other Medical Services 317,478 21 22 Laundry 54,658 22				
Substitute				
7				
SUBTOTAL Ancillary Revenue (lines 4 thru 7) S 599,550 8			599,550	
C. Other Operating Revenue 9 Payments for Education 9 10 Other Government Grants 10 11 Nurses Aide Training Reimbursements 11 12 Grift and Coffee Shop 12 13 Barber and Beauty Care 13 14 Non-Patient Meals 1,806 14 15 Telephone, Television and Radio 68 15 16 Rental of Facility Space 16 17 Sale of Drugs 317,888 17 18 Sale of Supplies to Non-Patients 18 19 Laboratory 129 19 20 Radiology and X-Ray 20 21 Other Medical Services 317,478 21 22 Laundry 54,658 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) 5 692,027 23 25 Interest and Other Investment Income*** 7,622 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) 7,622 26 E. Other Revenue (specify):**** 27 Settlement Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 6,076 28 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) 8 6,076 29 29 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) 8 6,076 29 29 20 20 20 20 20 20				7
9 Payments for Education 10 Other Government Grants 11 Nurses Aide Training Reimbursements 11 Qift and Coffee Shop 12 Gift and Coffee Shop 13 Barber and Beauty Care 14 Non-Patient Meals 15 Telephone, Television and Radio 16 Rental of Facility Space 17 Sale of Drugs 18 Sale of Supplies to Non-Patients 19 Laboratory 10 Radiology and X-Ray 20 Radiology and X-Ray 21 Other Medical Services 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 692,027 23 D. Non-Operating Revenue 24 Contributions 24 Contributions 25 Interest and Other Investment Income*** 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 7,622 26 E. Other Revenue (specify):**** 27 Settlement Income (Insurance, Legal, Etc.) 28 See Supplemental Schedule 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 6,076 29	8		\$ 599,550	8
10 Other Government Grants 10 11 Nurses Aide Training Reimbursements 11 12 Gift and Coffee Shop 12 13 Barber and Beauty Care 13 14 Non-Patient Meals 1,806 14 15 Telephone, Television and Radio 68 15 16 Rental of Facility Space 16 17 Sale of Drugs 317,888 17 18 Sale of Supplies to Non-Patients 18 19 Laboratory 129 19 20 Radiology and X-Ray 20 21 Other Medical Services 317,478 21 22 Laundry 54,658 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) 692,027 23 25 Interest and Other Investment Income** 7,622 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) 5 7,622 26 E. Other Revenue (specify):*** 27 Settlement Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 6,076 29 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) 5 6,076 29 29 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) 5 6,076 29 29 20 20 20 20 20 20		C. Other Operating Revenue		
11 Nurses Aide Training Reimbursements 11 12 Gift and Coffee Shop 12 13 Barber and Beauty Care 13 14 Non-Patient Meals 1,806 14 15 Telephone, Television and Radio 68 15 16 Rental of Facility Space 16 17 Sale of Drugs 317,888 17 18 Sale of Supplies to Non-Patients 18 19 Laboratory 129 19 20 Radiology and X-Ray 20 21 Other Medical Services 317,478 21 22 Laundry 54,658 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 692,027 23 D. Non-Operating Revenue 24 Contributions 24 25 Interest and Other Investment Income*** 7,622 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 7,622 26 E. Other Revenue (specify):**** 27 Settlement Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 6,076 <td></td> <td></td> <td></td> <td></td>				
12 Gift and Coffee Shop 12 13 Barber and Beauty Care 13 14 Non-Patient Meals 1,806 14 15 Telephone, Television and Radio 68 15 16 Rental of Facility Space 16 17 Sale of Drugs 317,888 17 18 Sale of Supplies to Non-Patients 18 19 Laboratory 129 19 20 Radiology and X-Ray 20 21 Other Medical Services 317,478 21 22 Laundry 54,658 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 692,027 23 23 D. Non-Operating Revenue 24 Contributions 24 25 Interest and Other Investment Income*** 7,622 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 7,622 26 E. Other Revenue (specify):*** 27 Settlement Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 6,076 28 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 6,076 29 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 6,076 29 20 20 20 20 20 20 20	-			
13 Barber and Beauty Care 13 14 Non-Patient Meals 1,806 14 15 Telephone, Television and Radio 68 15 16 Rental of Facility Space 16 17 Sale of Drugs 317,888 17 18 Sale of Supplies to Non-Patients 18 19 Laboratory 129 19 20 Radiology and X-Ray 20 21 Other Medical Services 317,478 21 22 Laundry 54,658 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 692,027 23 D. Non-Operating Revenue 24 Contributions 24 25 Interest and Other Investment Income*** 7,622 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 7,622 26 E. Other Revenue (specify):**** 27 28 See Supplemental Schedule 6,076 28 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 6,076 29				
14 Non-Patient Meals 1,806 14 15 Telephone, Television and Radio 68 15 16 Rental of Facility Space 16 17 Sale of Drugs 317,888 17 18 Sale of Supplies to Non-Patients 18 19 Laboratory 129 19 20 Radiology and X-Ray 20 21 Other Medical Services 317,478 21 22 Laundry 54,658 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 692,027 23 D. Non-Operating Revenue 24 24 Contributions 24 25 Interest and Other Investment Income*** 7,622 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 7,622 26 E. Other Revenue (specify):**** 27 28 See Supplemental Schedule 6,076 28 28a 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 6,076 29				
15 Telephone, Television and Radio 68 15 16 Rental of Facility Space 16 17 Sale of Drugs 317,888 17 18 Sale of Supplies to Non-Patients 18 19 Laboratory 129 19 20 Radiology and X-Ray 20 21 Other Medical Services 317,478 21 22 Laundry 54,658 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)\$ 692,027 23 D. Non-Operating Revenue 24 Contributions 24 25 Interest and Other Investment Income*** 7,622 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) 7,622 26 E. Other Revenue (specify):**** 27 28 See Supplemental Schedule 6,076 28 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) 6,076 29	_			13
16 Rental of Facility Space 16 17 Sale of Drugs 317,888 17 18 Sale of Supplies to Non-Patients 18 19 Laboratory 129 19 20 Radiology and X-Ray 20 21 Other Medical Services 317,478 21 22 Laundry 54,658 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 692,027 23 D. Non-Operating Revenue 24 25 Interest and Other Investment Income*** 7,622 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 7,622 26 E. Other Revenue (specify):**** 27 28 See Supplemental Schedule 6,076 28 28a 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 6,076 29			· · · · · · · · · · · · · · · · · · ·	
17 Sale of Drugs 317,888 17 18 Sale of Supplies to Non-Patients 18 19 Laboratory 129 19 20 Radiology and X-Ray 20 21 Other Medical Services 317,478 21 22 Laundry 54,658 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 692,027 23 D. Non-Operating Revenue 24 24 25 25 Interest and Other Investment Income*** 7,622 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 7,622 26 E. Other Revenue (specify):**** 27 28 See Supplemental Schedule 6,076 28 28a 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 6,076 29			68	
18 Sale of Supplies to Non-Patients 18 19 Laboratory 129 19 20 Radiology and X-Ray 20 21 Other Medical Services 317,478 21 22 Laundry 54,658 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 692,027 23 D. Non-Operating Revenue 24 Contributions 24 25 Interest and Other Investment Income*** 7,622 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 7,622 26 E. Other Revenue (specify):**** 27 28 See Supplemental Schedule 6,076 28 28a 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 6,076 29				
19 Laboratory 20 Radiology and X-Ray 21 Other Medical Services 21 Laundry 22 Laundry 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 692,027 23 D. Non-Operating Revenue 24 Contributions 25 Interest and Other Investment Income*** 25 Interest and Other Investment Income*** 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 7,622 25 27 Settlement Income (Insurance, Legal, Etc.) 28 See Supplemental Schedule 28 Subtotal Other Revenue (lines 27, 28 and 28a) 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) 20 Subtotal Other Revenue (lines 27, 28 and 28a) 317,478 21 22 22 22 23 317,478			317,888	
20 Radiology and X-Ray 20 21 Other Medical Services 317,478 21 22 Laundry 54,658 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 692,027 23 D. Non-Operating Revenue 24 25 Interest and Other Investment Income*** 7,622 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 7,622 26 E. Other Revenue (specify):**** 27 28 See Supplemental Schedule 6,076 28 28a 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 6,076 29		* *		
21 Other Medical Services 317,478 21 22 Laundry 54,658 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 692,027 23 D. Non-Operating Revenue 24 25 Interest and Other Investment Income*** 7,622 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 7,622 26 E. Other Revenue (specify):**** 27 28 See Supplemental Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 6,076 28 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 6,076 29			129	
22 Laundry 54,658 22 23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 692,027 23 D. Non-Operating Revenue 24 24 Contributions 24 25 Interest and Other Investment Income*** 7,622 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 7,622 26 E. Other Revenue (specify):**** 27 27 Settlement Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 6,076 28 28a 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 6,076 29				
23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$ 692,027 23 D. Non-Operating Revenue 24 Contributions 24 25 Interest and Other Investment Income*** 7,622 25 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 7,622 26 E. Other Revenue (specify):**** 27 Settlement Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 6,076 28 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 6,076 29				
D. Non-Operating Revenue 24 Contributions 25 Interest and Other Investment Income*** 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 7,622 26 E. Other Revenue (specify):**** 27 Settlement Income (Insurance, Legal, Etc.) 28 See Supplemental Schedule 28 Substantial Schedule 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) 20 Substantial Schedule 20 Substantial Schedule 21 See Supplemental Schedule 22 Substantial Schedule 23 Substantial Schedule 24 Substantial Schedule 26 Substantial Schedule 27 Settlement Income (lines 27, 28 and 28a) 28 Substantial Schedule 29 Substantial Schedule 20 Substantial Schedule 21 Substantial Schedule 22 Substantial Schedule 23 Substantial Schedule 24 Substantial Schedule 26 Substantial Schedule 27 Substantial Schedule 28 Substantial Schedule 29 Substantial Schedule 20 Substantial Schedule 20 Substantial Schedule 20 Substantial Schedule 21 Substantial Schedule 22 Substantial Schedule 23 Substantial Schedule 24 Substantial Schedule 25 Substantial Schedule 26 Substantial Schedule 27 Substantial Schedule 28 Substantial Schedule 29 Substantial Schedule 20 Substa				
24 Contributions 25 Interest and Other Investment Income*** 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 7,622 26 E. Other Revenue (specify):*** 27 Settlement Income (Insurance, Legal, Etc.) 28 See Supplemental Schedule 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 6,076 29	23		\$ 692,027	23
25 Interest and Other Investment Income*** 26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 7,622 26 E. Other Revenue (specify):**** 27 Settlement Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 6,076 28 28a 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 6,076 29				
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$ 7,622 26 E. Other Revenue (specify):**** 27 Settlement Income (Insurance, Legal, Etc.) 27 28 See Supplemental Schedule 6,076 28 28a 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 6,076 29				
E. Other Revenue (specify):**** 27 Settlement Income (Insurance, Legal, Etc.) 28 See Supplemental Schedule 28 See Supplemental Schedule 28 Substitute (lines 27, 28 and 28a) 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 6,076 29				
27Settlement Income (Insurance, Legal, Etc.)2728See Supplemental Schedule6,0762828a28a29SUBTOTAL Other Revenue (lines 27, 28 and 28a)\$ 6,07629	26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,622	26
28 See Supplemental Schedule 6,076 28 28a 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 6,076 29		E. Other Revenue (specify):****		
28a 28a 29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 6,076 29		Settlement Income (Insurance, Legal, Etc.)		27
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$ 6,076 29			6,076	
				28a
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29) \$ 11,836,396 30	29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,076	29
	30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,836,396	30

	o agamet expense	2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,464,457	31
32	Health Care	5,068,032	32
33	General Administration	3,121,869	33
	B. Capital Expense		
34	Ownership	694,059	34
	C. Ancillary Expense		
35	Special Cost Centers	457,298	35
36	Provider Participation Fee	123,735	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,929,450	40
41	Income before Income Taxes (line 30 minus line 40)**	(93,054)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (93,054)	43

*	This must	agree with	ı page 4,	line 45,	column 4.
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k *	Does this agree with taxable in	ncome (loss) per Federal Income				
	Tax Return?	If not, please attach a reconciliation.				

See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a SEE ACCOUNTANTS' COMPILATION REPORT detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

VILLA SCALABRINI NSG & REHAB

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

Facility Name & ID Number

3

	1	2 ~ ~	3	4				
	# of Hrs.	# of Hrs.	Reporting Period	Average				Nι
	Actually	Paid and	Total Salaries,	Hourly				0
	Worked	Accrued	Wages	Wage				P
1 Director of Nursing	1,690	2,011	\$ 62,137	\$ 30.90	1	1		Ac
2 Assistant Director of Nursing	1,806	2,151	60,114	27.95	2		Dietary Consultant	
3 Registered Nurses	48,417	58,295	1,461,464	25.07	3	36	Medical Director	M
4 Licensed Practical Nurses	17,154	19,693	375,405	19.06	4	37	Medical Records Consultant	
5 Nurse Aides & Orderlies	146,402	161,139	1,804,524	11.20	5		Nurse Consultant	
6 Nurse Aide Trainees					6	39	Pharmacist Consultant	
7 Licensed Therapist	1,051	1,265	32,751	25.89	7		Physical Therapy Consultant	
8 Rehab/Therapy Aides	9,666	11,123	142,150	12.78	8	41	Occupational Therapy Consultant	
9 Activity Director	350	393	8,509	21.65	9	42	Respiratory Therapy Consultant	
10 Activity Assistants	10,817	12,293	129,321	10.52	10		Speech Therapy Consultant	
11 Social Service Workers	14,369	15,031	285,748	19.01	11	44	Activity Consultant	
12 Dietician	3,210	3,731	69,254	18.56	12		Social Service Consultant	
13 Food Service Supervisor	4,949	5,495	109,304	19.89	13	46	Other(specify)	
14 Head Cook	5,543	6,213	72,548	11.68	14	47	Religious	
15 Cook Helpers/Assistants	37,399	40,496	311,802	7.70	15	48		
16 Dishwashers					16			
17 Maintenance Workers	13,681	16,406	245,591	14.97	17	49	TOTAL (lines 35 - 48)	
18 Housekeepers	27,390	30,245	307,112	10.15	18		•	
19 Laundry	15,013	16,782	146,173	8.71	19			
20 Administrator	1,144	1,434	59,783	41.69	20			
21 Assistant Administrator					21	C. C	CONTRACT NURSES	
22 Other Administrative					22			
23 Office Manager					23			Nı
24 Clerical	18,659	19,280	262,337	13.61	24	1		0
25 Vocational Instruction					25	1		P
26 Academic Instruction					26	1		Ac
27 Medical Director					27	50	Registered Nurses	1
28 Qualified MR Prof. (QMRP)					28	51	Licensed Practical Nurses	4
29 Resident Services Coordinator					29	52	Nurse Aides	5
30 Habilitation Aides (DD Homes)					30			
31 Medical Records	3,990	4,353	59,200	13.60	31	53	TOTAL (lines 50 - 52)	
32 Other Health Care(specify)			·		32		. , ,	
33 Other(specify) See Supplemental	5,298	5,718	106,023	18.54	33			
34 TOTAL (lines 1 - 33)	387,998	433,547	\$ 6,111,250 *	\$ 14.10	34	SEE ACC	COUNTANTS' COMPILATION REP	ORT

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	16,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant		543	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		4,114	11-03	44
45	Social Service Consultant		2,228	12-03	45
46	Other(specify)				46
47	Religious		3,866	12-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 26,751		49

C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses	1,764	\$ 74,083	10-03	50
51	Licensed Practical Nurses	4,369	157,293	10-03	51
52	Nurse Aides	5,109	122,620	10-03	52
53	TOTAL (lines 50 - 52)	11,242	\$ 353,996		53

^{*} This total must agree with page 4, column 1, line 45.

^{**} See instructions.

STATE	OF II	LLINOIS
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Page 21 Facility Name & ID Number
XIX, SUPPORT SCHEDULES # 0044792 VILLA SCALABRINI NSG & REHAB **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

XIX. SUPPORT SCHEDULES											
A. Administrative Salaries Ownership			D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions				
Name	Function	%	Amount	Description			Amount	Description		Amount	
Judith Perry	Administrator	\$	59,783	Workers' Compensation In	isurance	\$_	50,122	IDPH License Fee	\$_		
				Unemployment Compensa	tion Insurance		10,980	Advertising: Employee Recruitment			
				FICA Taxes			439,518	Health Care Worker Background Check		28	
				Employee Health Insuranc	e		935,612	(Indicate # of checks performed 2) -		
	<u> </u>			Employee Meals				Dues & Subscriptions		6,617	
	<u> </u>			Illinois Municipal Retirem	ent Fund (IMRF)*						
	<u> </u>			Dental/Life Insurance	,		46,738				
TOTAL (agree to Schedule V, line 17, col. 1)				Retirement Plan			135,059				
(List each licensed administrator separately.) \$			59,783	Group Disability			33,621		_		
B. Administrative - Other				Employee Assistance			6,733		_		
				Medical Screening/Other B	enefits		9,389	Less: Public Relations Expense	(-		
Description			Amount	Corp. Allocation of Tuition Reimbursement			7,254	Non-allowable advertising	` -		
Resurrection Intercompany Services			513,384				74,294	Yellow page advertising	` -		
			510,001	<u> </u>	71		,=> :	Tono w page auxorosomy	` _		
				TOTAL (agree to Schedul	e V.	\$	1,749,320	TOTAL (agree to Sch. V,	\$	6,645	
				line 22, col.8)			1,7 12,020	line 20, col. 8)			
TOTAL (agree to Schedule V, line 17, col. 3) \$ 513,38			513,384	E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**				
(Attach a copy of any management service agreement)			to Owners or Employees			Stream of Traver and Seminar					
C. Professional Services	ment service agreement)				•			Description		Amount	
Vendor/Payee	Tymo		Amount	Description	Line#		Amount	Description		Amount	
v endor/1 ayee	Туре	\$		Description	Line #	\$	Amount	Out-of-State Travel	C		
A -1-1 C - (4	Legal Details	>				- ³ -		Out-oi-State Travei	D _		
Achieve Software	Data Processing		3,214		<u> </u>				_		
Integrity Group	Computer Consultin	<u>g</u>	2,144					I Co t T	_		
								In-State Travel	_		
					<u> </u>				_		
									_		
									_		
								Seminar Expense	_	2,944	
									_		
						_					
									_		
								Entertainment Expense	(
TOTAL (agree to Schedule V,	line 19, column 3)			TOTAL		\$		(agree to Sch. V,	` _		
(If total legal fees exceed \$2500 attach copy of invoices.)		\$	5,376			=		TOTAL line 24, col. 8)	\$	2,944	

* Attach copy of IMRF notifications SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Report Period Beginning: 07/01/01

Ending:

Page 22 06/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3). (See instructions.)

3 5 6 8 10 11 12 13 2 4 Month & Year **Amount of Expense Amortized Per Year Improvement** Useful **Improvement Total Cost Was Made** FY1999 FY2000 FY2002 FY2003 FY2004 FY2005 FY2006 FY2007 Type Life FY2001 \$ \$ 2 3 5 6 8 9 10 11 12 13 14 15 16 17 18 19 20 **TOTALS**